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23 October 2010

A max strength, unique formula you can really feel

New Benylin Mucus Cough Menthol thins and loosens chest mucus with an immediate menthol sensation and invigorating taste.

Get it off your chest

Benylin®

McNeil Products Ltd
a Johnson & Johnson company

Supporting Pharmacy

Product information can be found overleaf

Send mucus packing this winter with Benylin® the N°1 selling Cough brand

Benylin Mucus Cough Product Information:
Presentation: Red syrup containing 100 mg Guaifenesin and 1.1 mg Levomenthol per 5 ml. **Uses:** Symptomatic relief of cough. **Dosage:** Adults and children over 12 years: 10 ml four times daily. **Contraindications:** Known hypersensitivity to ingredients. Use in children under 12 years. **Precautions:** Do not use in persistent or chronic cough, e.g. asthma, or cough accompanied by excessive secretions; caution in severe renal or hepatic impairment. **Pregnancy and Lactation:** Consult doctor. **Side effects:** Very rare. **RRP (ex-VAT):** 150ml £4.33; 300ml £6.37 **Legal category:** GSL. **PL Holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG. **PL No:** 15513/0056. **Date of prep:** June 2010.

Benylin Mucus Cough Menthol 100mg/5ml Syrup Product Information:
Presentation: Red syrup containing 100 mg Guaifenesin per 5 ml. **Uses:** Symptomatic relief of cough. **Dosage:** Adults and children over 12 years: 10 ml four times daily. Not recommended in children under 12 years. **Contraindications:** Known hypersensitivity to ingredients. **Precautions:** Do not use in persistent or chronic cough, e.g. asthma, or cough accompanied by excessive secretions; caution in severe renal or hepatic impairment; rare hereditary problems of fructose intolerance, glucose galactose malabsorption or sucrose-isomaltase insufficiency. **Pregnancy and Lactation:** Consult doctor. **Side effects:** Very rare. **RRP (ex-VAT):** 150ml £4.33. **Legal category:** GSL. **PL Holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG. **PL No:** 15513/0165. **Date of prep:** July 2010

Benylin Mucus Cough plus Decongestant Syrup Product Information:
Presentation: Orange-red syrup containing 100 mg Guaifenesin and 30mg Pseudoephedrine per 5 ml. **Uses:** Symptomatic relief of upper respiratory tract disorders with productive cough. **Dosage:** Adults and children over 12 years: 10 ml four times daily. **Contraindications:** Known hypersensitivity to ingredients; severe hypertension; severe coronary artery disease; with or within 2 weeks of receiving MAOIs; use in children under 12 years. **Precautions:** Mild to moderate hypertension, heart disease, diabetes, hyperthyroidism, increased intraocular pressure, prostatic enlargement, severe hepatic impairment, renal impairment. Do not use in persistent or chronic cough, such as occurs with asthma, or where cough is accompanied by excessive secretions. Not to be taken with any other cough or cold medicine. **Interactions:** Anti-hypertensive agents, tricyclic antidepressants and other sympathomimetic drugs, bretylium, betanidine, guanethidine, debrisoquine, methyldopa, alpha and beta blockers. **Pregnancy and Lactation:** Consult doctor. **Side effects:** Symptoms of CNS excitation including sleep disturbance and rarely hallucination, skin rashes and occasionally urinary retention. **RRP (ex-VAT):** 100ml: £2.97. **Legal category:** P. **PL Holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG. **PL No:** 15513/0022. **Date of prep:** June 2010

Benylin Mucus Cough Night Product Information:
Presentation: Red syrup containing 100 mg Guaifenesin, 1.1 mg Levomenthol and 14mg Diphenhydramine per 5 ml. **Uses:** Night-time relief of cough, associated congestive symptoms and aiding restful sleep. **Dosage:** Adults, the elderly and children over 12 years: 10ml at bedtime followed by 10ml every 6 hours. Do not take more than 20ml in 24 hours. Children under 12 years: contraindicated. **Contraindications:** Known hypersensitivity to ingredients. Not for use in patients taking, or who have taken in the last 2 weeks, MAOIs. Children under the age of 12 years. **Precautions:** Do not use in persistent or chronic cough, e.g. asthma, or cough accompanied by excessive secretions, unless directed by a doctor; caution in moderate to severe renal or hepatic impairment, and in narrow-angle glaucoma or prostatic hypertrophy. Avoid alcohol. Diphenhydramine may potentiate effects of alcohol, codeine, antihistamines, other CNS depressants, and may potentiate effects of anticholinergics e.g. psychotropic drugs and atropine. **Pregnancy and Lactation:** Consult doctor before use. **Side effects:** Diphenhydramine may cause drowsiness, dizziness, gastrointestinal disturbance, dry mouth and throat, difficulty in urination or blurred vision. Less frequently it may cause palpitations, tremor, convulsions or paraesthesia. Hypersensitivity reactions have been reported, in particular, skin rashes, erythema, urticaria and angioedema. Gastrointestinal discomfort, nausea and vomiting have been reported with guaifenesin, particularly in large doses. **RRP (ex-VAT):** 150ml £4.33 **Legal category:** P. **PL Holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG. **PL No:** 15513/0050. **Date of prep:** June 2009

McNeil Products Ltd. a Johnson & Johnson company

Supporting Pharmacy

Date of preparation: September 2010
ID: 06158

1. IRI HBA Outlets Volume Sales 52 w/e June 2010

Swap one combination for another

NiQuitin Minis Mint 1.5mg/4mg Lozenges (nicotine). Indication: smoking cessation. **Dosage: Adults (18 and over):** One lozenge (max. 15/day) whenever urge to smoke to aid complete cessation (brief use after 6 weeks) or gradual cessation (seek advice if no reduction after 6 weeks) or gradual cessation (seek advice if no reduction after 6 weeks or no abrupt attempt after 6 months). Professional advice if use >9 months. Use 1.5mg strength if smoke <20/day, otherwise 4mg. **Adolescents (12-17 years):** Abrupt cessation only as for adults but seek professional advice if >12 weeks treatment required to quit abruptly. **Contraindications:** Hypersensitivity and children under 12 years. **Precautions:** Risk of NRT substantially outweighed by risks of continued smoking in virtually all circumstances. Supervise use in those hospitalised for MI, severe dysrhythmia or CVA who are haemodynamically unstable. Once discharged, can use NiQuitin as normal. Susceptibility to angioedema, urticaria, renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma. Swallowed nicotine may exacerbate oesophagitis, gastric ulcer. **Pregnancy/lactation:** For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy for 2-3 months. Lozenge/gum preferable to patches unless nauseous. **Side effects:** At recommended doses, NiQuitin Minis have not been found to cause any serious adverse effects. Nausea, hiccup, flatulence, GI discomfort, vomiting, diarrhoea, dyspepsia, fatigue, malaise, chest pain, oral irritation, dizziness, headache, sleep disorders including abnormal dreams, anxiety, irritability, nervousness, depression, palpitations, increased heart rate, cough, sore throat, rash, anaphylaxis. See SPC for full details. GSL **PL** 00079/0610, 0611. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack sizes and RSP (excl. VAT):** 20's £4.75, 60's £13.32. **Date of revision:** August 2009.

NiQuitin 21, 14, 7mg Transdermal Patches, NiQuitin Clear 21, 14, 7mg (nicotine). Opaque or transparent transdermal patches 21mg, 14mg, 7mg nicotine (Steps 1, 2, 3) for relief of nicotine withdrawal symptoms during smoking cessation. **Dosage: Adults (18 and over):** ≥10 cigarettes/day: Step 1 for 6 weeks, then Step 2 for 2 weeks, then Step 3 for 2 weeks.<10 cigarettes/day: Step 2 for 6 weeks then Step 3 for 2 weeks. Apply to fresh site (clean, dry skin) once daily. Professional advice if use >9 months. **Adolescents (12-17 years):** As for adults but to seek professional advice if >12 weeks treatment required. **Contraindications:** Hypersensitivity, occasional/non-smokers, children under 12 years. **Precautions:** Risk of NRT substantially outweighed by risks of continued smoking in virtually all circumstances. Supervise use in those hospitalised for MI, severe dysrhythmia or CVA who are haemodynamically unstable. Once discharged, can use NiQuitin as normal. Susceptibility to angioedema, urticaria. Discontinue use if severe/persistent skin reactions. Renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma. **Pregnancy/lactation:** For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy for 2-3 months. Lozenge/gum preferable to patches unless nauseous. Remove patches at bedtime. **Side effects:** At recommended doses, NiQuitin patches have not been found to cause any serious adverse effects. Local rash, itching, burning, tingling, numbness, swelling, pain, urticaria, heaviness, hypersensitivity reactions. Headache, dizziness, tremor, sleep disorders, nervousness, palpitations, tachycardia, dyspnoea, pharyngitis, cough, GI disturbance, sweating, arthralgia, myalgia, malaise, anaphylaxis. See SPC for full details. GSL **PL** 00079/0368, 0367, 0366, 0356, 0355 & 0354. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack sizes and RSP (excl. VAT):** 7 patches £14.89; Step 1 only 14 patches £28.04. **Date of revision:** August 2009. **NiQuitin®, NiQuitin® Minis** and the **Minis Device** are trademarks of the GlaxoSmithKline group of companies.

Reference: 1. National Institute Clinical Excellence. Smoking cessation services in primary care, pharmacies, local authorities and work places, particularly for manual working groups, pregnant women and hard to reach communities. Public Health Guidance 10. February 2008.

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The Online Pharmacy Community

NiQuitin® Minis

NiQuitin® 21mg patch
CLEAR

Have your say on C+D's news. Email us at:
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"IN ANDREW LANSLEY'S FINANCIALLY-CHALLENGED NHS LANDSCAPE, OUTCOMES AND EVIDENCE RULE, WITHOUT EXCEPTION"

I gave a talk to some shiny new journalism students this week and tried to explain that there is a future for publishing but – and this is the difficult bit – it's likely to be a very different model from the one they are familiar with.

Their response was predictable enough: what's wrong with what we do now? Well, change – as most pharmacists will all too readily testify – is not easy. But when your surrounding landscape is changing at breakneck speed, change becomes a necessity that can't be ignored, which brings me nicely back to pharmacy.

Hot on the heels of his summer white paper, England's health secretary has this week revealed more details about how his "no decision about me without me" mantra will be delivered to patients by health professionals.

And while the latest DH consultation, An Information Revolution, does not specifically mention pharmacy, there is no reason why the sector would be excluded from having to demonstrate how it delivers measurable patient outcomes.

In Andrew Lansley's financially-challenged NHS landscape, outcomes and evidence rule, without exception. But just how does pharmacy prove its worth – is it through volumes of prescriptions dispensed, medication interventions made, medicine reviews conducted, public health messages delivered or OTC sales made?

It's probably all of these and more. But listing pharmacy's contribution is actually the easy bit, the challenge is in measuring the outcome of the thousands of interventions that pharmacists make every day. If we could collate that, it would present a very forceful case for realising the sector's ambitions.

One LPC has demonstrated just how this could be achieved however. Seven Essex pharmacies are taking part in a pilot to identify patients at risk of COPD (p8). Furthermore, if the scheme proves successful, the pharmacy service will be integrated into the overall COPD care pathway and pharmacists would play an increasing part in managing patients and their disease exacerbations and rehabilitation. And when you come to think about it, it's only by embedding pharmacy within local pathways that you get a true measure of its value.

It's a Catch 22 situation: pharmacy's worth can be best measured through integrating with local services, but for pharmacy to integrate with local services, it first needs to demonstrate the outcomes it can deliver. Faced with such inescapable logic, community pharmacy needs to get cracking with its data collection and fast.

Much like the journalism students I met this week, the next generation of pharmacists will be working under a different model from their predecessors. They'll be clinical practitioners first and dispensary managers second – but only if we can put the outcomes foundations in place today.

Gary Paragpuri, Editor

Most trusts engaging with sector on PNAs

EXCLUSIVE C+D finds 96 per cent of PCTs have consulted pharmacists

Zoe Smeaton
zoe.smeaton@ubm.com

Primary care trusts have on the whole engaged with LPCs and used PSNC templates while drawing up their pharmaceutical needs assessments (PNAs), C+D has found.

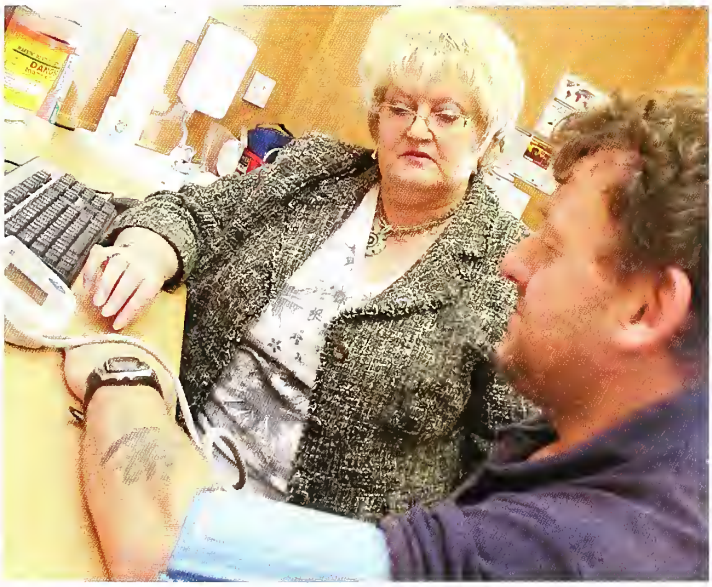
In an investigation to which over 100 trusts responded, 96 per cent said they had met with their LPCs to discuss the assessment in the past 18 months.

And 88 per cent had referred to PSNC template questionnaires on the topic.

The results were good news as engagement could mean the assessments, which will be used as the basis for service commissioning decisions in the future, were likely to be of a higher standard, experts said. But they added they had concerns where trusts were not engaging fully, and they urged pharmacists to respond to consultations on PNAs.

By February 2011, PCTs must have consulted on and signed off PNAs, following a 60-day consultation.

PSNC head of regulation Steve Lutener told C+D: "I am concerned about trusts that have not involved their LPCs during the development of the PNA." He said timescales were now "very tight" and warned where PCTs had not engaged fully they may have inadequate PNAs.



Trusts engaging pharmacy on PNAs could be good news for services, say experts

Experts also raised fears about the content of some PNAs, saying while some were very good, others were below standard. Mr Lutener continued: "Many PCTs at the moment are grappling with financial constraints. I am concerned that the PNA will be framed in a way that suggests that there are no needs for any commissioned services."

David Reissner, head of healthcare at law firm Charles Russell, told C+D he hadn't seen much evidence of PCTs going through all the criteria they needed to in PNAs.

How to respond to your local PNA

Full analysis on page 12

PNAs reaction

"PNAs are an amazing resource for contractors and essential reading. Contractors can be analysing PNAs and building their clinical business development plans around them."
Georgina Craig, pharmacy commissioning lead, NHS Alliance

"The draw back [of the PNA] is that this is a snap shot of what it looked like some 18 months ago and does not measure the willingness and commitment of existing providers to fill such gaps."
Salim Jetha, CEO, Avicenna

"There's a lot for us to go through so we have asked our pharmacists to check that the information is correct for their particular pharmacies. We are relying on LPCs to check otherwise."
John Evans, superintendent pharmacist, Asda

Generic substitution plans scrapped by DH

Pharmacy bodies have backed the Department of Health's (DH) decision to ditch its generic substitution plans. The plan to allow community pharmacists to dispense generics against branded scripts was laid out in January this year (C+D January 9, p6), but the department decided last week it would not go ahead with it.

PSNC said it was pleased with the news as the cost of implementing the plans would have outweighed the benefits. And the NPA said the department appeared to have taken into account warnings about patient safety, inter-professional relationships and workload.

The C+D Senate concluded earlier this year that generic substitution was not the most effective way for pharmacy to help reduce NHS costs (C+D, February 13, p18).

The BGMA, which represents generic manufacturers in the UK, also welcomed the DH decision and pointed out that generic competition already saves the NHS £8.6 billion a year.

Director Warwick Smith added: "We share their frustration at the remaining small amount of brand prescribing when there is no clinical reason not to use the equivalent but much more cost-effective generic." **HF**

MP Rosie Cooper has championed the work by staff at Rowlands Pharmacy in Digmoor, Skelmersdale following a visit last week in which she met the team and patients. Central Lancashire LPC and Rowlands Pharmacy jointly hosted the Labour MP for West Lancashire, who sits on the Parliamentary Health Select Committee. Rowlands area manager Neil Stewart, said: "She was very enthusiastic about the services we were offering and it was great we were able to introduce her to customers who use our services regularly." MR

Security concerns raised after pharmacy attack

Numark writes to NHS security service after thieves injure staff

Miriam Reissner

Pharmacy support group Numark has criticised the "despicable" lack of security support for pharmacy businesses, following a robbery at one of its members' branches.

The robbery at a North Meols Pharmacy in Halsall, Skelmersdale, left a member of staff needing stitches after he was hit on the left arm as the robbers stole car keys.

Numark managing director Tony Mottram said he had written to the NHS Security Management Service (SMS) and PSNC following the "shocking" incident.

The pharmacy on Halsall Road was targeted at around 4.30pm on October 11 by two men armed with a metal bar.

Pharmacy manager, Neil Barnes, was struck on the arm and is now off work. The men escaped in a stolen black Mazda 6 MPS saloon, which was parked in a car park opposite. Police have appealed for witnesses.

Superintendent pharmacist Shamir Patel told C+D CCTV and panic alarms had now been installed, but he said he had not found the NHS very helpful. "They are happy to put NHS logos on [the pharmacy], but when there is an incident we are an independent contractor to the NHS," he said.

Superintendent pharmacist Shamir Patel: funding needed for pharmacy security

Mr Patel called for more funding for pharmacy security measures, and Mr Mottram said: "It is despicable that our profession is ignored by the NHS Security Management Service despite being in the front line of NHS services."

PSNC chief executive Sue Sharpe said: "It's a sad reality that necessary security measures represent an increasingly significant cost for a growing number of pharmacies." She said these costs must be recognised following the cost of service inquiry.

Richard Hampton, head of the NHS Security Management Service, told C+D: "While the NHS SMS doesn't deal directly with the private premises of contractors, it certainly takes into account the security concerns of the wider health community working outside the NHS security structure."

Mr Hampton added that he would be happy to discuss the safety of staff with Numark.

C+D Senate calls for service reform

C+D Senators called for national commissioning in order to get rid of "postcode lotteries" at the C+D Senate Live last week.

They said the whole country needed to look at "beacon areas" such as Hampshire & Isle of Wight to improve the current local commissioning model.

The Senators were responding to C+D's PCT Investigation (October 9, p4 onwards) which showed stark differences between areas across England for services commissioned in pharmacy.

Senator and PSNC chief executive Sue Sharpe said smoking cessation and minor ailments should be commissioned as essential services, and CCA chief executive Rob Darracott said national specifications would help multiples.

Mr Darracott said: "Clearly national companies would prefer to have as many things agreed at the national level as possible as obviously that will help in taking those services into reality locally."

Senators said the NHS white paper was a chance for pharmacy to redefine how it gets its funding.

Lindsey Gilpin, chair of the RPS English Pharmacy Board, said the Society had a vision of pharmacists having an expanded clinical role. This would mean a move away from volume and towards being paid for a role in clinical care, she added. She also thought central funding would "avoid this postcode lottery." **HF**

More from the C+D Senate Live

Read more from the C+D Senate Live on page 14. For videos of the live debate, plus full coverage of the C+D Conference go to **www.chemistanddruggist.co.uk**

In brief

C+D journalist awards

C+D editorial staff have been nominated for three awards at the highly acclaimed PTC New Journalist of the Year Awards. Deputy and features editor Jennifer Richardson has been shortlisted for the new section editor of the year award. Clinical editor Chris Chapman and news editor Zoe Smeaton are shortlisted in the category for new business news journalist.

Nice database

A database of Nice guidance recommendations on primary care referral advice has been launched to help improve patient care.
www.chemistanddruggist.co.uk

NCSO endorsement

The Department of Health and National Assembly for Wales have agreed to allow an NCSO endorsement for citalopram 20mg tablets for October 2010 prescriptions.

MHRA clamp down

The MHRA seized £570,000 worth of illicit pills between October 5 and 12, as part of an international operation against the online sale of counterfeit and illegal medicines.
www.chemistanddruggist.co.uk

Stock survey on BBC

C+D editor Gary Paragpuri has appeared on the BBC's The One Show discussing the results of the C+D Stock Survey 2010. The programme showed the extent of shortages being experienced by community pharmacists.
www.chemistanddruggist.co.uk/stocksurvey2010

Free prescriptions

Free prescriptions for all are to go ahead in Scotland, it was announced at the SNP conference last weekend.

DH consultations

The Department of Health has launched consultations on proposals for patient care and information. They include plans to allow patients to choose from any willing provider.
www.chemistanddruggist.co.uk

Dispensary talk

How well do you think pharmacy has lobbied ministers?

"Lobbying has been proactive in inviting ministers to pharmacies, which is positive, but things don't seem to be changing; we are waiting for them to take that back to parliament and get results."
Lorraine Moore, Rowlands Pharmacy, Sunderland

"It's about time that pharmacy asserted its position as a health provider to the government."
Julie Key, Murrays Healthcare, Tipton, West Midlands

Web verdict

We've done a great job 0%

Pharmacy bodies could do more
10%

Everyone needs to do more
20%

Absolutely hopeless
70%

Armchair view: It seems former health secretary Alan Milburn's comments that the sector needs to lobby more effectively were not unfounded, with not a single person thinking pharmacy has done well and most branding the efforts as hopeless.

Next week's question:
What do you make of your PCT's pharmaceutical needs assessment? Vote at
www.chemistanddruggist.co.uk

COPD service launches

Screening test in mid-Essex pharmacies could lead to greater role

Chris Chapman
chris.chapman@ubm.com

Pharmacists in Mid Essex PCT have embarked on an innovative service to help identify patients with chronic obstructive pulmonary disease (COPD).

If successful, the trial could see pharmacists playing a greater role in the integrated COPD care pathway, working alongside other healthcare professionals.

The six-month pilot sees seven pharmacies equipped with a spirometer, which can be used to test patients for their risk of COPD.

Pharmacists identify patients at possible risk and offer the screening test. Any patients identified are referred to their GP for diagnosis.

Pharmacists will be paid £25 per test, which is documented using a form developed with the PCT.

Patients may also be signposted to smoking cessation services, asthma clinics or local self-help groups, or offered an MUR if appropriate.

Ash Pandya, chief executive of Essex LPC, welcomed the service as a "good model for future collaboration" with other healthcare professionals. He said: "This project is unique, in that it has arisen out of close collaboration between the PCT, secondary care and the LPC."

If the service is successful, pharmacists in Essex would be further integrated into the COPD care pathway, playing an increasing part in management of the condition, exacerbations and rehabilitation, Mr Pandya added.

Asim Mirza, pharmacist at Borno Chemist in Witham, said he was enthusiastic about the new service.

"We're keen to offer it," he said. "I envisage it's going to be successful, and the training is easy to understand. It's good for pharmacy."

Students fire recruitment warning over fees

The profession could see recruitment plummet if students are priced out by government plans to remove an upper limit on tuition fees charged by universities, the British Pharmaceutical Students' Association (BPSA) has warned.

The plans, which outline graduate contributions made payable after university, were backed by business secretary Vince Cable following the review of higher education funding by Lord Browne.

However, BPSA president Louise Hemmings warned a rise in tuition fees would deter students from applying to take longer courses, such as pharmacy. She said: "Students already finish university with over £12,000 of debt from tuition fees, with maintenance loans on top. If fees are increased then students will end up paying off their student loans for their entire working career." **CC**

Clinical debate — C+D's Chris Chapman looks at the evidence behind the headlines

Making the most of the evidence

Last week the BMJ published a systematic review on reboxetine, which claimed it was no better than placebo in response rates and worse than other SSRIs for remission rates and response rates. Interestingly, the analysis said 74 per cent of data on these patients had not been published, and data that was, overestimated the benefit of reboxetine versus placebo by up to 115 per cent.

Now, more generally, publication bias – where studies are more likely to be published if they show a positive result – is the bane of a robust evidence base. The BMJ article authors call for the mandatory publication of all trial data, suggesting this would remedy such problems.

Reboxetine manufacturer Pfizer responded, stating that it "discloses the results of its clinical trials to regulatory authorities. These regulatory authorities carefully balance the risks and benefits of each medication and reflect all important safety and efficacy information in the approved product labelling".

Pfizer added that it is reviewing the analysis results and will comment further when the review is completed.

But just because all information is available does not mean it will be applied, as the recent suspension of rosiglitazone revealed.

The cardiovascular risk associated with rosiglitazone has been known for years. In 2006 the European Medicines Agency updated the product information, and in 2008 said it had "a small, if diminishing, place in diabetes type 2 therapy".

Yet when the drug was suspended last month, an estimated 90,000 patients in the UK were still on the drug – which suggests the message wasn't getting through well enough.

Rosiglitazone has shown more needs to be done in terms of highlighting advice from bodies such as the MHRA and Nice.

Pharmacists have a role in medicines management and prescribing advice that needs to be pushed and promoted, especially by the professional leadership body, and pharmacists need to be empowered to deliver this advice by the Department of Health.

Only when this role is accepted in an integrated health team will we be able to transform data into patient outcomes.

Chat with Chris on Twitter:
www.twitter.com/CandDChris

Button down kids' cold & flu symptoms this winter

Supported by a major nationwide TV campaign

When children over six need effective relief from colds, flu and nasal symptoms, recommend CALCOLD Six Plus. You can rely on it throughout the season to quickly tackle their runny noses, sneezing, fevers, sore throats, aches and pains, and ease their breathing.

Trust the makers of Calpol to have kids' colds and flu covered

alCold Six Plus Product Information:
resentation: Strawberry flavour solution containing 120mg Paracetamol nd 12.5mg Diphenhydramine hydrochloride per 5ml. **Uses:** Treatment of ild to moderate pain in children 6-12 years, including teething pain, eadache, sore throat, aches and pains for the symptomatic relief of fluenza, feverishness, feverish colds and associated symptoms of runny se and sneezing. **Dosage:** *6 - 12 years*: 10ml - 20ml three times daily. **ontraindications:** Use in children under 6 years; hypersensitivity; with or ithin two weeks of receiving MAOIs; large doses of anti-histamines may recipitate seizures in epileptics. **Precautions:** Not more than 3 doses should be taken in 24 hours. Not to be used for more than 3 days without the advice of a doctor. Caution in hepatic or moderate to severe renal dysfunction, urinary retention, angle-closure glaucoma or symptomatic prostatic hypertrophy; avoid use with alcohol or other sedating medicines; fructose intolerance; may cause drowsiness; interaction with domperidone, metoclopramide, colestyramine, anticoagulants, anticonvulsants and oral contraceptives; may have an additive muscarinic action; may potentiate effect of alcohol, and other CNS depressants. See SPC for further details. **Pregnancy and lactation:** Consult doctor before use. **Side effects:** Hypersensitivity including skin rash; blood dyscrasias; drowsiness, paradoxical stimulation, headache, psychomotor impairment, gastrointestinal disturbance, dry mouth, urinary retension, blurred vision, thickened respiratory tract secretions. Rarely hypotension: palpitations, tremor, convulsions. Chronic hepatic necrosis and papillary necrosis have been reported. See SPC for further details. **RRP (ex-VAT):** 100ml: £2.98. **Legal category:** P. **PL holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG **PL no:** 15513/0145. **Date of prep:** September 2009

ID: 06175

McNeil

In brief

£5 million for Oral-B

Oral-B has announced a television campaign with a total spend of £5 million. The advertisement will appear on television screens until the end of the year, with the strapline 'Seize Power Today'. The television campaign will be supported by print, online and in-store activity, including a 50 per cent discount offer in a number of retailers.

No more Regaine regular

Regaine for Men Regular Strength and Regaine for Men Gel will be phased out in the forthcoming months and ultimately discontinued, Johnson and Johnson has announced, due to increasing demand for Regaine For Men Extra Strength 5 per cent Solution. The 5 per cent solution is suitable for the majority of people currently using the 2 per cent product, says the company.

Slow retail growth

September was the sixth month in a row to show poor retail sales growth, reports the British Retail Consortium, with a like-for-like rise of 0.5 per cent. Toiletries and cosmetics picked up a little, but were often promotion-driven. Cold weather helped skincare and cough/cold remedies, while suncare, first aid and hayfever sales slowed. Perfumery benefited from new launches.

BioCare adds probiotic

BioCare has added probiotic capsule Bio-Acidophilus Forte Plus to its Bio-Acidophilus range. The addition is "the most potent probiotic capsule on the market", says the manufacturer, which has also increased the potency of other products in the range.
Tel: 0121 433 3727

Dettol special for Boots

Reckitt Benckiser's Dettol No Touch Hand Wash will be available in a special edition in Boots. The brand has joined forces with Chapman Entertainment to provide Roary the Racing Car and Fifi and the Flowertots sticker packs with the product, which can be used to create a decorated soap dispenser.
www.rb.com

Bassetts adds teen supplements

Ernest Jackson & Co has added two new products specifically for teenagers to its Bassetts Soft & Chewy supplements range.

Healthy Balance has been specially developed for young women, Bassetts says, and contains multivitamins and evening primrose oil to help promote skin and hormone health.

Sport Health has been developed to support those who lead active lives, containing a range of B vitamins as well as coenzyme Q10.

Prices: £6.99/30 Healthy Balance; £4.99/30 Sport Health

Market focus

- The vitamins and minerals market is worth £400 million.
- Pharmacy has a 35 per cent share of this category.

Source: Kantar Worldpanel, year to August 9, 2009

Pip codes: 354-3055; 355-4615
Ernest Jackson & Co
Tel: 01363 636100
www.bassettsvitamins.co.uk

Actavis and Omega Pharma team up in trading partnership

Actavis and Omega Pharma (formerly trading as Chefaro) have announced a trading partnership beginning this month.

The partnership is aimed at generating market growth, the companies say, by improving detailing, display and distribution to pharmacies across the UK.

Omega Pharma sales director Kay Patton says the company's investment in its sales force will allow increased contact with local pharmacy and more opportunity to build strong relationships with the independent sector.

Actavis UK
Tel: 0800 373573
customerservice@actavis.co.uk

Mam trio new to babycare product range

Babycare manufacturer Mam has added three products to its range.

The products include a soft brush for cleaning feeding bottles, a microwave bottle steriliser and an anti-colic starter set.

The Mam Soft Brush is made from a material that can flexibly adapt to the shape of the bottle; the end of the brush can be used as a teat cleaner and it contains a hanger so the brush can be stored, a spokesperson says.

The Microwave Steam Steriliser for feeding bottles takes four minutes to sterilise six bottles in the microwave and, if left sealed, will remain sterilised for 24 hours, according to the company.

The Anti-Colic Starter Set comprises the components for eight bottles in three different sizes. They are supplied with handles and a spout, enabling them to be turned into cups.

There is also a Mam soother, plus sealing discs to turn the smaller bottles into milk storage pots, the spokesperson adds.

Prices and Pip codes: See C+D Monthly Price List and www.cddata.co.uk
Enterprise
Tel: 0208 943 8880
www.mambaby.com

On TV next week

Covonia: All areas
Hedrin: GMTV, five, Sat
Just for Men: All areas
Lyclear: GMTV, five, Sat
Otrivine: C4, five, GMTV, Sat
Oxy: All areas apart from C4, five
Seabond: All areas
Seven Seas Cod Liver Oil: All areas
Vagisil: All areas
PharmaSite for next week: Pharmaton – windows, **Pharmaton** – in-store, **Pharmaton** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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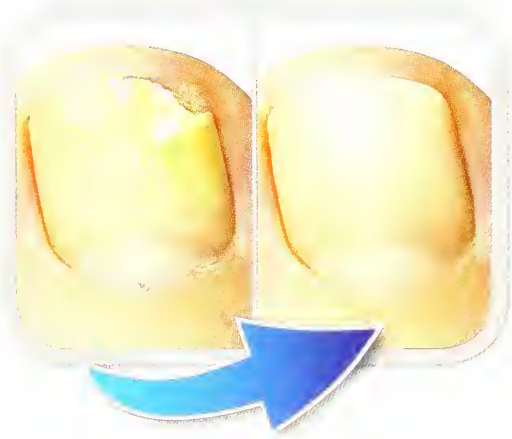
Scholl Fungal Nail Treatment

Bringing Back Healthier Looking Nails

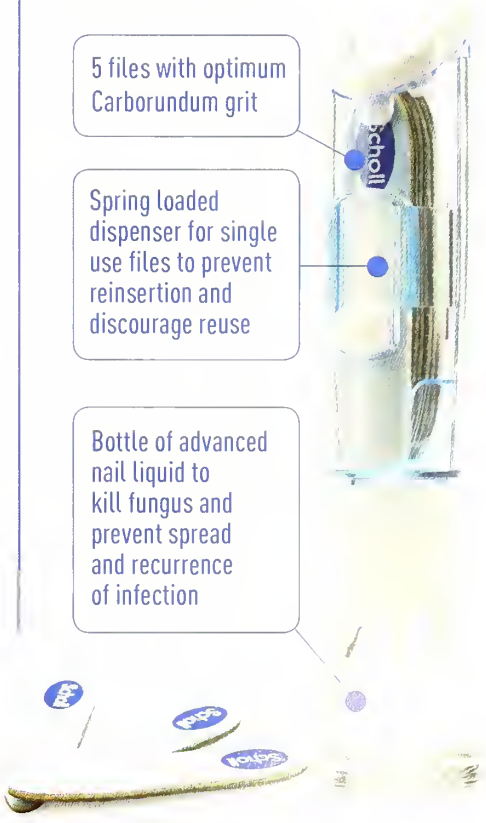
An easy to use, all-in-one topical treatment for mild Fungal Nail:

- **Scientifically proven to be effective in treating Fungal Nail**[1]
- **Helps prevent the spread of infection and recurrence**
- **4 week intensive treatment phase** to kill the fungi
- **9-12 month protection phase** until the healthy nail grows back
- Visibly improves the appearance of the nail
- Dermatologically tested
- One pack contains a full course of treatment



Innovative design

Scholl Fungal Nail Treatment comes in a unique, intuitive device, designed to fit discretely into a bag or bathroom cabinet.



For more information on Scholl Fungal Nail Treatment visit www.scholl.co.uk or call the Scholl team on 0800 074 2040.

1. Data on file.

Scholl

great feet feeling

Sch87 01

For all the latest pharmacy IT news go to
www.chemistanddruggist.co.uk/ITzone

PNAs: too important to ignore

COVER STORY As the future of the NHS remains a mystery, **Zoe Smeaton** asks why pharmacists should still be worrying about their local pharmaceutical needs assessments

With newspapers highlighting them, patients groups responding to them and local pharmaceutical committees (LPCs) scrutinising their every word, pharmaceutical needs assessments (PNAs) – although they may not sound like the most exciting reads – are difficult to ignore at the moment.

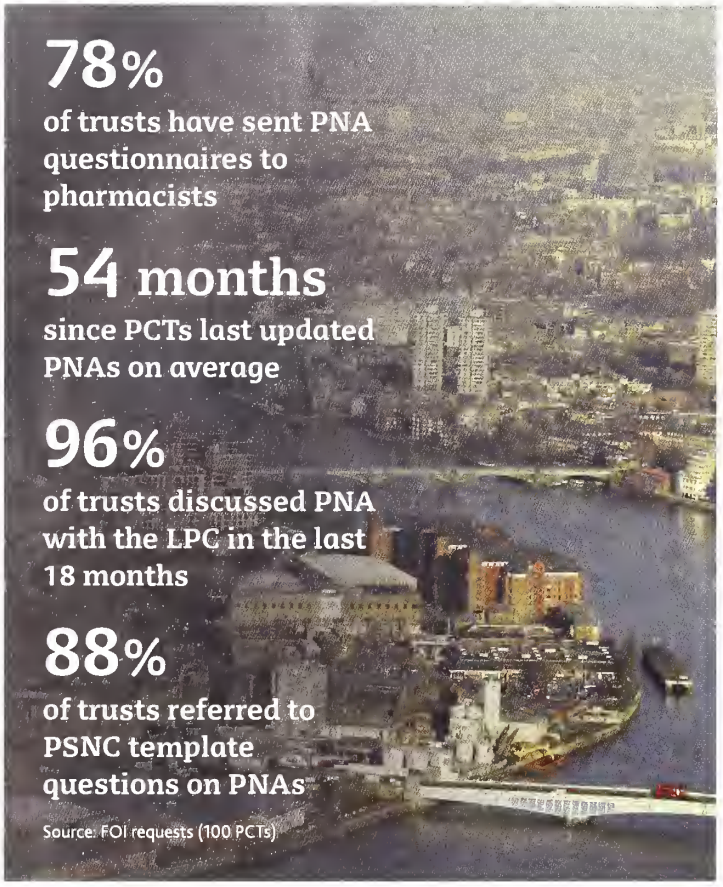
PCTs are at last starting to get to grips with the assessments and most either have, or are about to have, a version out for consultation. And with the deadline for having sign-off approaching in February 2011, and at least a two-month consultation period required before then, it's probably about time they did.

But with the trusts on their way out under radical NHS reforms, pharmacists are right to ask just how much PNAs are going to matter in the future. Experts are unanimous in their response to this, however: they do matter, and you do need to look at them.

Simply put, the documents are going to be used as commissioning tools, identifying health needs so services can be planned around them, and industry leaders think for this reason they will always be useful.

Jonathan Mason, the Department of Health's community pharmacy tsar, points out that, whatever the NHS looks like in future, needs assessments are always going to be an important function. It's difficult to tell exactly how the documents will be used, but it's possible GP consortia will need to consider them, for example. And as the documents are supposed to link to joint strategic needs assessments (JSNAs) produced with local authorities, they're unlikely to be completely forgotten.

Furthermore, even if considering them isn't vital in future, pharmacy could use them as evidence for services it would like to offer. As one PCT employee told C+D, the assessments provide real evidence-based documents showing the need for services: "Pharmacy has got a very powerful weapon here if they are used correctly – they can present these documents to commissioners as evidence for the need for services."



> "Pharmacy has got a very powerful weapon here if PNAs are used correctly"
>
> PCT EMPLOYEE

Where they work, this should all bode well for pharmacy. And the good news is that C+D has found, using the Freedom of Information Act, that in the last 18 months 96 per cent of trusts have met with their LPCs to discuss the PNA (see p6), which must be a start at least. But multiples have told C+D the PNAs they have seen are not consistent, with some good and others "a mish-mash mosaic" of information.

It's clear where they are not good pharmacy needs to have a say – but how can you tell good from bad and what exactly should you look for when your PCT puts its PNA out for consultation?

If you can't face reading the whole thing, the most important points to check are the ones about your own pharmacy, looking at whether they are accurate. For example, John Evans, superintendent pharmacist at Asda, says one PNA had commented that the nearest parking to an Asda pharmacy was over half a mile away, when in fact there were nearly 1,000 spaces in the store car park.

Errors or omissions can be dangerous. As Steve Lutener, head of regulation at PSNC, says: "If the PNA map of current providers does not show all pharmacy premises, then that could mean that the PCT has not taken into account services being provided by the pharmacy. If the public look at the PNA when they are seeking out services, then the 'missing' pharmacies could lose out." Furthermore, as PNAs may be used as the basis for entry to the sector in future, if it appears on the PNA that existing pharmacies are not meeting a need even if, in reality, they are, the trust could be obliged to allow new applications to succeed regardless of the existing businesses.

Things are tricky here as there is a delicate balance to be struck. On the one hand it could be good for the PNAs to identify gaps in service provision, giving scope for new services and possibly pharmacies, but on the other, these gaps need to be genuine or competition may become unsustainable. PSNC is urging contractors to look at the documents and where necessary align their offering to the needs identified, and multiples have told C+D this is their strategy.

This can be a useful business planning exercise to ensure you are really meeting your patients' needs, and means you can respond to the consultation explaining your willingness to provide services in the future.

If you're struggling, try contacting your LPC for help with a PNA. Mr Mason says you could also compare the assessments with JSNAs to ensure no key health needs have been missed. Colleagues and other local contractors may also be willing to discuss the document with you.

But, however you do it, you should take the time to respond to the consultation. As Mr Mason says: "Pharmacists should be reading what is in there and if they're happy with it they can just say so. If they feel there are statements relating to their pharmacy that are wrong or questionable, it's very important that they do respond."

And with the deadlines looming, it's probably now or never for the documents that may very well shape the sector's future.

PNA answers

Read C+D's Q&A with PSNC's head of regulation Steve Lutener on why and how you should respond to PNAs, at **www.chemistanddruggist.co.uk**

Enough talk, what does it mean for me?

"UNBEKNOWN TO ME, I'VE BEEN MAKING HAY WHILE THE SUN SHINES AND IT'S FAMINE COME JANUARY"

Keats said autumn was the season of mists and mellow fruitfulness, but he forgot about conferences. After the political conventions it's been the turn of pharmacy, and normally I'd treat them all as just so much hot air if it wasn't such a time of change. So with honest self-interest I read the C+D conference reports last week because just like at budget time, what we want to know is – what does it mean for us? And when I read the headline "Where does pharmacy fit in?", what I was thinking was "never mind pharmacy – where do I fit in?!".

Yet again came the idée fixe of pharmacy punching below its weight with our political masters and that, according to former health secretary Alan Milburn, we need to speak with one voice. But we know we can never be united in the same way as the BMA. Let's face it, the most united community pharmacy can be is akin to the EU – disparate factions with a common aim. Like EU countries, each independent or chain or multinational are their own enclave lobbying for improvements in terms, but an improvement that suits their demographic makeup, and each with different ideas about how best to achieve that.

So what does it mean to me? In between the umpteen calls to manufacturers for their restricted stock and having to register yet again for waste disposal exemption, I read about Sue Sharpe telling me to make the most of my current NHS cheques because – unbeknown to me – I've been making hay while the sun shines and it's famine come January!

The infamous treasury note for the coalition government that said "Sorry – there's no money left" seems to have been passed onto the PSNC.

But even if a united voice can't call for extra money for pharmacy, couldn't we agree to reduce our costs? If we can't be paid more for drugs, why not campaign to make it cost less to dispense them? That means addressing the stock shortages and supply system – actually doing something rather than just talking about it would be a start. Then there's the administrative burden of everything from clinical governance assessments and standard operating procedures, to the general ubiquitous business red tape. And finally there is the common farcical plethora of PCT claim forms.

The NHS acronym of the moment is QIPP – quality, innovation, productivity and prevention. In other words "new ways, same quality, less money" and maybe that's what we need. If Helen Gordon is going to present pharmacy up as a "low-cost healthcare provider", the NHS will want to know what healthcare we can provide – but I'll want to know how my own costs are going to be lowered.

Can pharmacy follow the lead of the GPs and present a united voice to the DH?

haveyoursay@chemistanddruggist.co.uk

If you're going to use the law, get it right

I have noticed an increase in PCTs using legal sticks with which to beat 100-hour pharmacies. I have to be neutral about 100-hour pharmacies, because I have some clients who own them and others who object to them. But if PCTs are going to use the law, they had better get it right.

A number of PCTs have been trying to use powers under LPS regulations to designate an area in which they say they are interested in awarding a contract for local pharmaceutical services, then announce they will not consider any applications for contracts. I suspect the motive is to avoid having to grant applications for 100-hour contracts. However, some of these designations are of dubious legality and I have successfully challenged some of them.

Then there's Christmas opening. The NHS terms of service say that for the purpose of counting core hours, pharmacies are deemed to have been open on Christmas Day and bank holidays if they would ordinarily have been open on that day of the week. Bank holidays are defined in the Banking and Financial Dealings Act 1971. In England, the definition includes December 26 – or December 27 if, like this year, December 26 falls on a Sunday.

So Boxing Day will not be a bank holiday this year. This could be a problem for pharmacies that ordinarily open on Sundays, if pharmacists want December 26 with their families, or because they want to give their staff that day off.

This is an issue for supermarket pharmacies that are normally open for 100 hours a week. It is obviously impractical to open a pharmacy within a store that is closed. However, some PCTs have shown little tolerance, insisting that in-store pharmacies should open, often without taking into account other pharmacies that are open.

At about 6pm on Christmas Day last year, my daughter received her secret code number for Tamiflu. My wife and I set off for the nearest open pharmacy. We rang ahead and the pharmacist, who was due to close, agreed to stay open till we got there. This year, I hope that instead of fixating on pharmacies that close at Christmas, PCTs will join me in paying tribute to the ones that open.

David Reissner is a specialist in pharmacy law and head of healthcare at Charles Russell LLP (www.charlesrussell.co.uk). Contact him on 0207 203 5065 or email david.reissner@charlesrussell.co.uk

Should 100-hour pharmacies open on bank holidays?

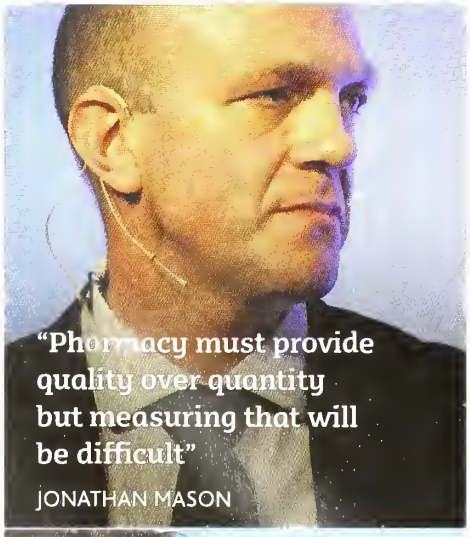
haveyoursay@chemistanddruggist.co.uk

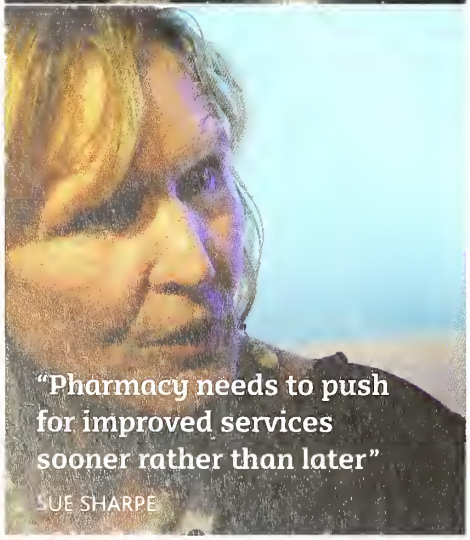
"THIS YEAR I HOPE THAT THE PCTs WILL JOIN ME IN PAYING TRIBUTE TO THOSE PHARMACIES THAT ARE OPEN ON CHRISTMAS"

C+D Senate LIVE

The community pharmacy think-tank

TOPIC: The PCT spending lottery





The first live C+D Senate debated the 'shocking' PCT Investigation results, reports **Hannah Flynn**

The findings were shocking, the figures unacceptable, the Senators agreed. The week C+D's 2010 PCT Investigation revealed the sorry state of local enhanced services commissioning, sector leaders gathered at the C+D Conference to dissect the results and decide what community pharmacy must do to improve the situation.

The Department of Health's national clinical director for pharmacy, Jonathan Mason, was the first Senator to be asked if the figures (see PCT Investigation: the key findings, opposite) were acceptable. Clearly not, he told the Senate's first live audience, at the Pharmacy Show where the conference was held. And if the situation was going to change, he said, then the current model for pharmacy was going to have to change, too.

Mr Mason, who is also head of prescribing and pharmacy at City and Hackney PCT, says that if pharmacy wants to move towards a more clinical role then more funding is going to have to be derived from clinical services. This means that pharmacists must question if they want to continue to have a role in procurement, he says. Mr Mason explains: "I am not for a moment saying procurement is something we want to get rid of and clearly the government would have a view on that.

"What I am saying is that if a clinical route is what we want to do then we have to give something up, and we need to put a framework together that would allow us to do that. Only then will we be able to deliver and drive the income up."

All the Senators agree that, though the results of the PCT Investigation were disappointing, there were many areas of the country that were shown to be providing excellent levels of service.

Senator and PSNC chief executive Sue Sharpe says that while there is a varying picture across the country, some areas have LPCs and PCTs that are working together well. As an example, she says: "You have got some PCTs like [Mr Mason's] and like Hampshire & Isle of Wight PCT who have really 'got it' about how they can use pharmacy and have really good relations with the LPCs, good levels of commissioning [and] fantastic uptake by pharmacies."

Mrs Sharpe recommends that the sector take a look at what these "beacon" areas are doing that is leading to such a high level of success, and emphasises how important it is to get more services commissioned on a national level.

Referring to Hampshire & Isle of Wight's Healthy Living Pharmacy scheme in Portsmouth, Mrs Sharpe says: "We really need to be shouting and pushing for this kind of thing to be funded in and invested in so that this kind of pharmacy [service] can be delivered across the country."

Senator and CCA chief executive Rob Darracott strongly agrees. He points out that while the average figures may mask some of the success stories in pharmacy in England, it would be best if services were commissioned on a national level.

Mr Darracott says: "Clearly national companies would prefer to have as many things agreed at a national level or a national specification as

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www.chemistanddruggist.co.uk

possible, as obviously that will help in taking those services into reality locally."

And Mrs Sharpe and Mr Mason both say that pharmacy needs to be pushing for improved services sooner rather than later, as the recent NHS white paper signals a big change in commissioning frameworks.

Mr Mason points out that, in order to maximise the opportunities presented by the white paper, pharmacy needs to develop a framework that measures outcomes.

He says the paper means that pharmacy and other NHS providers will need to provide quality over quantity, but measuring that meaningfully will be difficult. Mr Mason says: "We have a minor ailments service in my PCT and, yes, we know how many interventions there are, but the outcomes of those interventions? We have no idea.

"And unless we can say, 'We saw this many patients and we know so many of them were prevented from seeing their GP or going to a walk-in centre, which would have cost you even more as a PCT', unless we have that information, as a commissioner it is very difficult to make decisions about commissioning."

Senators agree that pharmaceutical needs assessments (PNAs) could hold the key to better commissioning, but only if both pharmacists and commissioners take them seriously.

NPA chairman Ian Facer believes PNAs have been done well by PCTs. However, Mr Facer says the unanswered question is where PNAs sit in regard to control of entry.

He says that there are "huge concerns around the exemptions and so on, and how do they fit going forward with PNAs? And that's a point I raised this week with the [pharmacy] minister to ensure we had some clarity around that. So generally my impression is that the unanswered question is: 'How are they going to be used and will they be used properly?'."

Senators agree that C+D's PCT Investigation has unveiled a worrying picture of local enhanced services commissioning. But with the PCTs about to be disbanded and the future of commissioning unclear, Senators are clear on just one other thing: now is the time pharmacy must shout about what it can offer the NHS if it is going to survive the changes outlined in the white paper.

The Senate Ruling

1. **The current state of local enhanced services commissioning, revealed by C+D's PCT Investigation, is unacceptable.**
2. **Pharmacy must learn from the local success stories that do exist.**
3. **The sector must push for more nationally commissioned and/or national service specifications.**
4. **Pharmacists must find a way to measure the patient outcomes of their services.**

Next week in C+D: The Senate proposes a new funding model

PCT INVESTIGATION

PCT Investigation: the key findings

£0
Lowest reported spend on enhanced services per pharmacy

12
Number of PCTs who reported an enhanced service spend per pharmacy of more than £10,000

57%
Proportion of PCTs responding who have a pharmacy minor ailments scheme

£2,486
Average spend on enhanced services per pharmacy

3 steps to breaking down barriers at your PCT

Pharmacy tsar Jonathan Mason explains what to do if you are experiencing problems with your local trust

1. Find the right person to talk to in the PCT. If it is not the pharmacy prescribing team or the primary commissioning team, talk to the chair of the PCT as they can be a very powerful advocate.

2. If you feel your work is not being recognised, get the chair of the PCT or the non-executive directors to come into the pharmacy to see what you are doing.

3. Find an advocate in the PCT in your field. If the problem is with methadone dispensing, for example, get in touch with your local drug action team as they wield a lot of power.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on local services

REFLECT	Do I understand how local enhanced services affect my pharmacy and patients?
PLAN	Consider how the white paper proposals could affect the services my pharmacy offers.
ACT	Read relevant sections of the white paper and related documents, and gather evidence of how my services are helping patients and the NHS.
EVALUATE	Do I better understand how local commissioning affects my pharmacy and patients, and how it might change?

Update

Your weekly CPD revision guide

Module 13 of 18

60-second summary

Why read this article?

Leukaemia accounts for 4,000 deaths in the UK each year. While it is the most common form of childhood cancer, more than 90 per cent of patients are adults. This Update details the risk factors and signs and symptoms of this potentially fatal condition.

What are the main types of leukaemia?

Leukaemia targets the myeloid cells, which fight bacterial and parasitic infection and prevent the spread of tissue damage, or lymphocytes, specifically B- and T-lymphocytes that are the linchpin of the immune system. Both types of leukaemia may be acute or chronic.

What are the symptoms?

Symptoms of leukaemia are related to bone marrow failure and the effects of organ infiltration. Individual symptoms will vary depending on the type of leukaemia and how advanced it is. In many cases, symptoms are vague and non-specific, with similarities to common influenza. A final diagnosis can only be confirmed by a conclusive blood test and biopsy results. Patients displaying hallmarks – especially swollen lymph glands – should be referred to their GP.

To get Update emailed to you each week, register for CPD Zone newsletter at www.chemistanddruggist.co.uk/register

Leukaemia: part 1

The incidence, risk factors and diagnosis of this type of cancer

Helen Boreham MSci

Leukaemia is a cancer of the bone marrow and blood characterised by the uncontrolled growth and accumulation of immature white blood cells (blasts). Unable to function like mature healthy leukocytes, these abnormal cells instead fill and flood the bone marrow, blocking normal haematopoiesis. The resulting disruption to the carefully controlled balance of white cells, red cells and platelets seriously compromises the body's infection-fighting, oxygen-carrying and blood-clotting capabilities. Blasts can also infiltrate the organs and build up in the lymphatic system.

Leukaemia is the 13th most common cancer in the UK and accounts for approximately 2.5 per cent of all British cancer cases.[1] Overall, around 7,400 people in the UK are diagnosed with leukaemia each year, equivalent to 20 people every day.[1] Despite being the most common form of childhood cancer, over 90 per cent of cases are actually diagnosed in adults.[1]

The incidence of leukaemia in the UK had been increasing slowly over time up until the end of 1990s, fuelled partly by better diagnosis and recording. However, the last few years have seen a shift in this trend, with a slight fall in incidence rates since the start of the new millennium. Today, the lifetime risk of developing leukaemia is estimated at one in 76 for men and one in 108 for women in the UK.[1]

Types

There are four key kinds of leukaemia, classified according to the type of white blood cell affected and the speed at which the cancer develops:

- acute myeloid leukaemia (AML)
- acute lymphoblastic leukaemia (ALL)
- chronic myeloid leukaemia (CML)
- chronic lymphocytic leukaemia (CLL).

Myeloid leukaemia targets the myeloid cells (principally monocytes and granulocytes) that fight bacterial and parasitic infection and prevent the spread of tissue damage.[2] Lymphoblastic leukaemia affects the lymphocytes, specifically B- and T-lymphocytes, which are the linchpin of the immune system.

Leukaemia can develop slowly, with a gradual onset of symptoms and protracted progression over a number of years requiring no immediate treatment. This is chronic leukaemia. In contrast, acute leukaemia advances rapidly and aggressively. Symptoms can become life-threatening quickly and immediate intervention is imperative.

Around 2,200 cases of AML are diagnosed each year in the UK – mostly in patients aged over 65 years.[1] In contrast, ALL is rare in adults but is the most common type of childhood leukaemia. Of the 600 ALL cases diagnosed each year, half are in adults and half in children.[1]

CLL is the most common type of chronic leukaemia, with 2,300 patients diagnosed each year.[1] It is more prevalent in the over 60s and very unusual in patients under 40 years old. In comparison, CML is rare – with only 600 cases occurring per year, equivalent to one in every 500 cancers diagnosed in the UK.[1]

Signs and symptoms

Symptoms of leukaemia are related to bone marrow failure and the effects of organ infiltration. Generally these include:

- tiredness and lack of energy
- breathlessness
- pale skin
- mild fever or night sweats
- slow healing of cuts
- abnormal bruising or bleeding
- petechial rash (small red or purple spots under the skin)
- bone and joint pain (caused by pressure from cells building up in the marrow)
- swollen lymph nodes
- left side abdominal pain (indicative of an enlarged spleen)
- repeated infections
- loss of appetite
- weight loss
- itchy skin.

Individual symptoms vary depending on the type of leukaemia and how advanced it is. In many cases, symptoms are vague and non-specific, with similarities to common influenza. In chronic leukaemia, there may be a total absence of symptoms.

The majority of CML patients present during the chronic phase of the disease and around half of these will be asymptomatic, with the cancer diagnosed by chance following a routine blood test for another condition.[3]

Diagnosis

The key diagnostic tests for leukaemia are a full blood count and bone marrow biopsy. Blood tests indicate whether white cell levels are low or high, reveal any abnormal leukaemic cells in the blood and identify deficiencies in platelet or red cell count. Bone marrow biopsy is a ►►

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Table 1: Risk factors for leukaemia development[1,2]

- **Immunosuppression**

Patients with HIV/AIDS or organ transplant recipients on long-term immunosuppressives have double or triple the normal risk of leukaemia.

- **Age**

The risk of AML, CML and CLL increases with age.

- **Gender**

ALL and CML are more common in men than women.

- **Genetic disorders**

ALL occurs with 20- to 30-fold higher frequency in patients with Down's syndrome.

- **Autoimmune conditions**

Patients with rheumatoid arthritis, autoimmune haemolytic anaemia and ulcerative colitis have between three to eight times the normal risk of developing AML. This may be due to the autoimmune disorder itself or because of the pharmacotherapy used to treat it.

- **Benzene exposure**
- **Other blood disorders – eg aplastic anaemia**
- **Smoking**

Smoking doubles the risk of AML and may account for as many as 17 per cent of all myeloid leukaemia cases.

- **Family history**

The risk of CLL is six- to nine-fold higher for first-degree relatives of a CLL patient.

- **Radiation exposure**

Radiotherapy treatment for other types of cancer confers an increased risk of acute leukaemia.

Diagnostic X-rays during pregnancy have been linked to an increased risk of leukaemia in the child.

- **Past chemotherapy**

Chlorambucil, melphalan or cyclophosphamide for Hodgkin's lymphoma or breast cancer carry a small increase in the risk of blood changes that may lead to AML.

Etoposide, mitoxantrone, amsacrine and idarubicin are associated with a slightly raised risk of ALL.

Survivors of childhood cancer have 10 times the normal risk of developing leukaemia 10 years post-treatment.

- **Alcohol during pregnancy**

One study found the risk of AML in the first 18 months of life was more than doubled if the mother consumed alcohol during pregnancy.

- **Weight**

A BMI ≥30 is associated with a slightly increased risk of AML and a 25 per cent higher risk of developing CML.

- **Occupation**

Certain occupations have been linked to increased risk of developing chronic leukaemia – likely due to inherent chemical or pesticide exposure. These occupational risks extend to: agricultural workers, rubber or plastics manufacturers, tailors and dressmakers, cleaners, builders and labourers.

confirmatory tool to verify the presence of cancerous cells and check the type of leukaemia.

Further investigations may also be carried out to shed light on the progress and extent of the leukaemia and offer insights into the best treatment strategy. These include:[2]

- cytogenic testing to analyse the genetic make-up of the cancerous cells and assess sensitivity to treatment
- immunophenotyping to identify antigens present on leukaemic cells
- lymph node biopsy to assess how far the leukaemia has spread
- scans (CT, MRI, x-ray or ultrasound) to establish the health of other organs and check for lymph node or spleen enlargement.

Differential diagnosis

Leukaemia presents with a diffuse set of symptoms potentially attributable to a whole host of different, and considerably more common, conditions. Differential diagnosis based on symptoms alone is therefore extremely challenging.

In clinical practice, although symptoms may raise the index of suspicion, a final diagnosis of leukaemia can only be confirmed by conclusive blood test and biopsy results. Patients displaying any of the hallmarks potentially indicative of leukaemia – particularly swollen lymph nodes – should be referred to their GP for rule-out blood tests. In these cases it is important to offer reassurances that, in the vast majority of patients, the symptoms are extremely unlikely to be caused by leukaemia.

Cause

Leukaemia is a complex disease involving intricate, interwoven cellular pathways with no clearly-defined cause. In some types of leukaemia, a genetic component is obvious. Between 90 and 95 per cent of patients with CML carry a chromosomal abnormality known as the Philadelphia (Ph) chromosome, where genetic material is translocated between chromosomes 9 and 22.[3,4] The resulting Ph chromosome contains the bcr-abl oncogene, which expresses a tyrosine kinase enzyme with increased proliferative activity, key to the development of chronic phase CML.[3,4]

For a list of risk factors, see table 1, left.

In childhood acute leukaemia, there is considerable support for a 'two-hit' hypothesis. According to this theory, children born with a pre-existing vulnerability to acute leukaemia (such as a genetic mutation) remain healthy unless exposed to an environmental trigger (the second hit) that initiates disease development.[2]

Pathophysiology

Leukaemia begins with DNA mutations in the bone marrow stem cells. The term lymphoblastic denotes the fact that cancerous changes occur in a type of marrow cell that forms lymphocytes, while myeloid indicates that the cell changes take place in the type of marrow cell that normally goes on to form red blood cells, some types of white cell and platelets.[5]

AML can develop from either myeloid stem cells or myeloid blasts. The result is an overproduction of immature granulocytes or monocytes. In CML, the myeloid stem cells or bone marrow stem cells themselves can become leukaemic, resulting in cancerous granulocyte white blood cells. As a result, CML is sometimes referred to as chronic granulocytic leukaemia (CGL). ALL and CLL both affect the lymphoid lineage; ALL develops from lymphoid blast cells, whereas CLL affects B-lymphocytes.

In acute leukaemia, normal bone marrow is completely displaced by a malignant clone of immature blasts.[6] Chronic leukaemias, on the other hand, have few or no blast cells.[5] White cells are almost fully grown when leaving the bone marrow so can function (albeit suboptimally); however, counts are high and continue to rise too rapidly, with loss of infection-fighting properties over time.

CML has three distinct phases – chronic, accelerated and blastic. The chronic phase can last anywhere from three months to 22 years, with periods of disease dormancy extended since the discovery of new oral therapies. Progression, which is triggered by further rumblings of genomic instability, usually starts with the accelerated phase.[4] After six to 12 months, this progresses to the blastic phase – also known as blast crisis – which behaves similarly to AML and is typically fatal within six months.[3]

Prognosis

The prognosis for patients with leukaemia is continuing to improve. In the last 30 years, five-year survival rates have more than tripled, with around 40 per cent of patients now surviving the disease for at least five years after diagnosis.[1] Nevertheless, leukaemia still accounts for over 4,000 deaths each year in the UK.[1] The majority of these mortalities (80 per cent) occur in patients aged over 60 years.[1]

Helen Boreham is a freelance medical writer with an MSci in medicinal chemistry

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References

1. Cancer Research UK www.cancerresearchuk.org
2. NHS Choices www.nhs.uk
3. Duncan N. Adult myeloid leukaemias: pathogenesis, clinical features and classification. Clinical Pharmacist 2010; 2: 117-121
4. Smith V. Chronic leukaemia – characteristics and treatment. Hospital Pharmacist 2003;10:110-16
5. Leukemia & Lymphoma Society www.leukemia-lymphoma.org
6. Nijjar R. Acute leukaemia – characteristics and treatment. Hospital Pharmacist 2003; 10: 99-107

NEXT WEEK
Part two of our guide to leukaemia looks at treatment and management options

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Leukaemia: part 1

Which type of leukaemia is most commonly seen in children? What chromosomal abnormality are patients with CML likely to have? Which occupations have been linked to an increased risk of chronic leukaemia?

This article describes the four main types of leukaemia: acute myeloid leukaemia, acute lymphoblastic leukaemia, chronic myeloid leukaemia and chronic lymphocytic leukaemia. It includes information about signs and symptoms, diagnosis, causes, risk factors and the pathophysiology of the disease.

- Find out more about the types of leukaemia from the Merck online manual at http://tinyurl.com/leukaemia01.
- Revise your knowledge of blood cell types and learn more about the tests used in leukaemia diagnosis and the Philadelphia chromosome from the American National Cancer Institute website at http://tinyurl.com/leukaemia02.
- The Leukaemia and Lymphoma Research website has detailed booklets about each of the leukaemia types containing information that may be useful for your patients at http://tinyurl.com/leukaemia07, http://tinyurl.com/leukaemia09, http://tinyurl.com/leukaemia10, http://tinyurl.com/leukaemia11.

Are you now familiar with the different types of leukaemia? Could you recognise the symptoms? Are you confident in your knowledge of the causes, risk factors and pathophysiology of this disease?

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Practical Approach

A disabled job applicant

David Spencer, pharmacist at the Update Pharmacy, receives a phone call from Meir Godol, a friend and proprietor of a nearby pharmacy.

Meir says: "David, I've got a bit of a dilemma and I know I can rely on you for sound advice."

"OK," says David, "tell me about it."

"Well, I've advertised for a new pharmacy technician. In response, I got a call from a chap who sounded ideal, so I said I'd send him an application from. He then told me that he had an accident on his motorbike six months ago. He was fully fit again now, but he's paralysed from the waist down and in a wheelchair. Now I don't know what to do. As you know, my dispensary's quite small and I'm worried that if I took him on I'd have to make expensive alterations to the whole shop to accommodate him.

"On the other hand, if I turned down his application he might take action against me for discrimination. Do you think I could get round the problem by saying in the job description I send out with the application form that the job is not suitable for a disabled person?"

David replies: "It's not a situation that I'm familiar with I'm afraid. But I do know that new legislation came into force this month that might have a bearing on the situation."

Questions

1. What is the new legislation that came into force this month and does it have a bearing on Meir's situation?
2. Assuming that the disabled applicant was the most suitable for the job, would Meir be forced to make expensive modifications to his premises to accommodate him?
3. Could Meir get round the problem by saying that the job is not suitable for a disabled person?
4. What should Meir do?

Answers

1. The Equality Act 2010. It brings together several Acts and Regulations, including the Disability Discrimination Act (DDA), in an attempt to simplify anti-discrimination legislation. It would have no additional bearing on Meir's situation.

2. No, Meir would be obliged only to make reasonable adjustments. These might include removing any physical barriers that would make it difficult for the employee to get round the shop and dispensary, and modifying facilities to make stock, equipment, and so on more accessible.

3. No. Meir cannot say this unless, in the terms of the Equality Act it can be "objectively justified", eg a blind person could not be a delivery van driver.

4. Offer the applicant an interview. Meir is obliged to ask if he needs any reasonable adjustments to be made for him to attend. If these cannot be made, the interview might have to be held somewhere other than his pharmacy. Let the applicant see the premises so that he can decide whether, with any reasonable adjustments, he would be able to work there. Under the legislation, the applicant could only be turned down if the necessary changes would be so extensive as to be unreasonable. Meir might need to take specialist advice on this.

References

- Actavis Back Office Briefings. June 2010 dilemma: Disability. (www.actavisacademy.co.uk/?pgid=1970)
- Equality and Human Rights Commission. Guidance for Employers. (www.equalityhumanrights.com/uploaded_files/EqualityAct/employers_recruitment.pdf)

Got an idea for a Practical Approach scenario or would you like to write one? Email your suggestion to: **haveyoursay@chemistanddruggist.co.uk**

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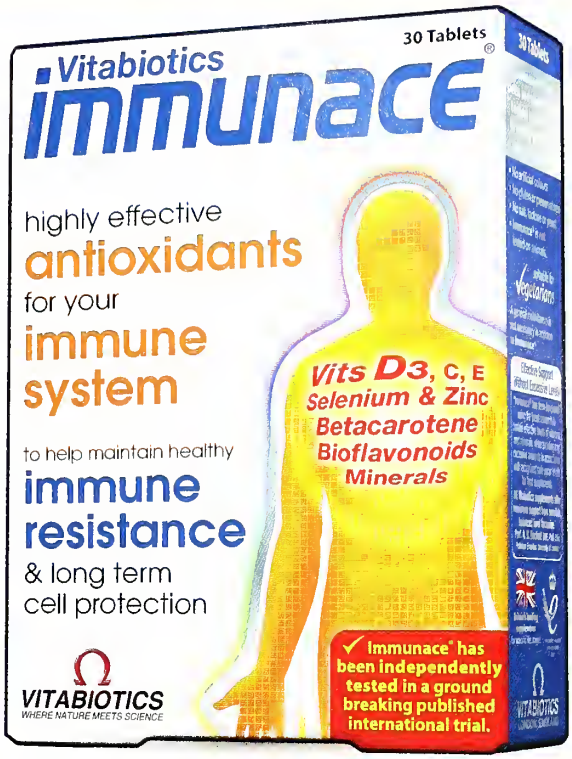

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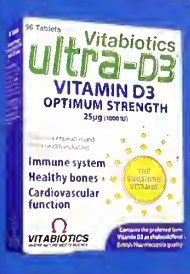

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Postscript...

Ceuta chief scoops awards

Awards season has reached Ceuta Healthcare early as they scooped two awards in the past week.

Portsmouth-based Ceuta won the award for Best New Partnership for its brand-fostering agreement with P&G at the European Outsourcing Awards 2010.

Edwin Bessant (left), co-founder and chief executive of The Ceuta Group, has received the Deloitte Director of the Year Award for Healthcare and Life Sciences.

A social tweet

From public speaking to conferences, join the debate at www.twitter.com/chemistdruggist

@CandDZoe: Just about recovered from the Pharmacy Show and my conference chairing debut – glad to be back in the comforting surroundings of news pages

@jonathanmason: @CandDZoe – you did a good job chairing the session – very professional

@jonathanmason: Thinking about our new professional leadship body – I think we need to support the new RPS

@pgmimmo: @jonathanmason do you mind if I frame that tweet and put it on my wall :-)

C+D reader of the week

Meet Aina Osunkunle, who would like to go back to the days of the Roman Empire

Where are you going to go on your next holiday? Hopefully Barcelona, as it is a place I have never been before. My friends have told me it is very beautiful.

Why did you chose to become a pharmacist? When I was young I had a very good chemist near my home and I thought how wonderful it would be to have a profession and a business. I also really like interacting with the public.

What's the strangest request you have ever had? I had one customer come in for some medicine, and after I had explained the possible side effects she said she was going to use it on her horse. She said the horse probably wouldn't be able to tell her if it had any side effects.

What would you do if someone gave you £1,000? I would go away on a long holiday or go shopping and treat myself.

If you could go back in time, where would you go? I would like to go to the Roman world, as I find the Roman Empire quite interesting.

What's your favourite book? The Bible is my favourite book as it's interesting and there is everything in there.

What are you going to have for lunch? I usually have a salad with some salmon and prawns.

What object can you not live without? I can not live without my food!

What is your guilty pleasure? Food, lots and lots of food. High fat and high calorie ones. Peanuts are my undoing.

What question should we ask our next reader of the week? What would you most like to contribute to the world?

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

The Victorian Pharmacist

"To ascertain whether a sample of petroleum is sufficiently volatile to be dangerous..."

Dear Sir,

I wish to propose the following solutions to common problems which plague our noble profession, which others may find of use.

According to an anonymous correspondent in the Lancet, honey is a superior vehicle for the administration of quinine to children and others for whom the flavour of this drug is nauseous. If the alkaloid be placed in the centre of a small spoonful of honey, I venture to surmise that the bitterest repugnance to the flavour will be entirely overcome. I have tried glycerine, milk and other vaunted specifics; but, as our American friends say, they are "not a patch" on honey.

Acute eczema of the hands is, according to Dr Van Harlington of Philadelphia, cured by the application of saturated solution of boric acid, and this solution is particularly useful where there are numerous vesicular lesions inclining to coalescence and break down into eczema rubrum.

To ascertain whether a sample of petroleum is sufficiently volatile to be dangerous, Herr Montag points out a very simple and conclusive method.

Fill a glass three parts full of the petroleum, and fill up the glass with boiling water, at the same time holding a flame over it. If the vapors disengaged becomes ignited, the petroleum should not be considered a safe liquid to leave exposed to the atmosphere. This mode of testing might easily be adopted as standard!

I hope others of the trade may benefit from these suggestions.

The Victorian Pharmacist's suggestions were first published in October 1884, when a spoonful of honey helped the medicine go down, and everyone was igniting petrol in their dispensary. Do you have an old solution to a problem you want to share? Email postscript@chemistanddruggist.co.uk

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References: 1. Hjalmarson A, et al. Arch Intern Med. 1997; 157: 1721–1728. **2.** Leischow SJ, et al. Am J Health Behav 1996; 20(5): 364-371.

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